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A project was designed to provide therapy for disadvantaged children in New York City nonpublic schools who have the additional handicap of defective speech. Effectiveness of speech teachers in providing therapy services was evaluated. The measurements of effectiveness were determined from the following: trained speech pathologists' observation of the speech teachers and completion of an evaluative form, teachers' responses to a questionnaire assessing the therapy program, and an interview with the program administrators. A total of five trained speech pathologists visited 15 schools and interviewed 13 speech teachers; 30 of the 38 teachers completed the questionnaires. Recommendations included speech teachers' screening of all children in grades 3 to 7 using a clinical rating scale; administration of diagnostic tests to children being considered for therapy; definite referral procedures with coordination and followup; greater flexibility in therapy methods, particularly for older children; the establishment of regional supervisory centers; improvement and expansion of speech teachers' contacts with parents of children in therapy and with other school personnel; and continuation of the orientation program. (GD)

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# EVALUATION OF NEW YORK CITY TITLE I

# EDUCATIONAL PROJECTS 1966-67

## SPEECH THERAPY FOR DISADVANTAGED PUPILS IN NONPUBLIC SCHOOLS

By Seymour Rigrodsky

September 1967

EC 002 070

**The Center For Urban Education**
33 West 42nd St., New York, N.Y. 10036

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33 West 42nd Street
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# SPEECH THERAPY FOR DISADVANTAGED PUPILS IN NONPUBLIC SCHOOLS

Seymour Rigrodsky

Evaluation of a New York City school district educational project funded under Title I of the Elementary and Secondary Education Act of 1965 (PL 89-10), performed under contract with the Board of Education of the City of New York for the 1966-67 school year.

Committee on Field Research and Evaluation
Joseph Krevisky, Assistant Director

September 1967

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# I. PURPOSE OF THE PROJECT

This project is designed to provide therapy for disadvantaged pupils who have the additional handicap of defective speech. "Defective" in this sense refers to speech anomalies which interfere with communication and are severe enough to cause anxiety for the child and/or render him conspicuous. Such problems include: stuttering, voice disorders, cleft palate, cerebral palsy, lisping, lalling, and other articulatory defects.

Alleviation of pupil speech problems should contribute to improved emotional adjustment and educational achievement. As these pupils improve in their ability to communicate, it is expected that they will develop greater social effectiveness and become more easily integrated in the mainstream of the community.

This program was to provide speech therapy once a week in small groups (maximum group size set at ten). The speech correction teacher would confer with classroom teachers to keep them informed as to pupils' needs and progress and to enlist their assistance in carry-over of gains in clinic sessions to speaking situations in the pupils' normal environment. Parents would be informed about the child's participation in the speech therapy program. Speech teachers would confer with parents as needed.

Referrals for hearing tests, physical examinations, psychological evaluations, and other services related to the speech defect would be

made through the School Health Services, the Bureau of Child Guidance, and appropriate community agencies as needed.

All of the 38 teachers to be involved were licensed as substitute teachers of Speech Improvement by the New York City Board of Education.

A basic kit was to be available at each location, each consisting of such items as file cabinets, desks, chairs, tape recorder, record player, tests, and books.

In line with recommendations made in the 1966 evaluation conducted by the Center for Urban Education, a uniform diagnostic test was to be administered to each child enrolled for therapy.

## II. PURPOSE OF THE EVALUATION

The purpose of the evaluation was to measure the overall effectiveness of the speech teachers in carrying out their assignment of providing speech therapy services to disadvantaged children in nonpublic schools. For the purposes of this evaluation the measurement of effectiveness was determined by direct observation of the speech teachers during therapy sessions, from a questionnaire sampling of teachers' opinions of their therapy effectiveness, from a collection of vital statistics obtained from the questionnaire, and from an interview with the administrators of the program. The methods used in this program were also compared to program guides and techniques used throughout the country. Since the project itself had to be initiated prior to the time when the evaluation was being formulated, it was impossible to do a direct clinical research program which would have evaluated change in speech of a selected sample of children. In summary, this evaluation consists of a critical review of all procedures used in the program rather than a direct measurement of pupil progress. An additional objective of this evaluation was to develop a series of recommendations or guide lines which would be of value in planning future programs. Recommendations for future evaluations were also made.

Program limitations include the following: prior to this year, the program was in existence for only a couple of months; the special

and unique regulations of each nonpublic school resulted in scheduling and room assignment problems; and the late arrival of some equipment and supplies deferred implementation of parts of the program.

## III. PROCEDURES

### A. Method of Evaluation

The major concern of the evaluation was to sample the knowledge, skill and opinions of the speech teachers employed in the project. Data for the evaluation were obtained from interviews with the administrators of the project and from a comparison of the program with current practices used throughout the nation. Teachers were observed by experienced and trained speech pathologists as they performed therapy in several schools with different age level children. Following each observation, teachers had an opportunity to discuss their lessons, their goals, and their entire program with the field evaluators. A questionnaire (Appendix B) was distributed to 38 speech teachers,[1] the total number employed, to be completed individually and returned to the project director. One of the research associates prepared and synthesized all the available state guidelines for programs of this type. A similar analysis was made of guidelines recommended and published by the American Speech and Hearing Association.[2]

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1. Kornhauser, A. and Sheatsley, P., "Questionnaire Construction and Interview Procedure", Appendix C in Selltiz, C., et.al., Research Methods in Social Relations, Rev. Ed., (New York: Holt, Rinehart and Winston, 1959).

2. Mack D. Steer, Project Director, "Public School Speech and Hearing Services" in Journal of Speech and Hearing Disorders, Monograph Supplement 8, July 1961.

1. A clinical observation form was developed by the project director (Appendix B).

2. Five trained speech pathologists (two hold doctorates, the remaining three are advanced doctoral students and all with a minimum of two years of clinical experience including some public school experience) including the project director, observed actual therapy and then returned their written forms to the director. It is possible that the personal bias of each evaluator, particularly his feelings about appropriate therapy technique, colored the observation he made. The project director, following an interview with each field evaluator, believes that the evaluators entered the observation in good faith and tried to report as objectively as possible.

3. The five evaluators visited 15 schools and interviewed 13 speech teachers (there were 177 schools in the program staffed by 38 speech teachers offering full day and half day sessions) located in the Bronx, Manhattan and Brooklyn. The schools chosen for observation represented the Catholic, Jewish and Protestant faiths. Each visit usually included observation of at least two class sessions.

4. The questionnaire was distributed to the speech teachers, soliciting opinion and fact regarding every aspect of the program. Thirty completed questionnaires from a possible total of 38 were received and analyzed.

5. An interview with the director of the program and the speech supervisor elicited their opinions as to the effectiveness of the program and the problems they faced in preparing and administering it.

6. A comparison was made between the procedures recommended by 24 state programs,[3] the current literature,[4] and the American Speech and Hearing Association monograph,[5] and the methods used in the present program. This comparison included screening procedures, diagnostics, therapy placement, therapy grouping, and size of therapy groups.

The information collected in the above mentioned procedures served as the basic source for data used to arrive at conclusions about the program and for establishing recommendations.

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3. Arizona, Arkansas, California, Connecticut, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Michigan, Missouri, Nebraska, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Virginia, Washington, Wisconsin.

4. Martha E. Black, Speech Correction in the Schools, (New Jersey: Prentice-Hall, 1965).
J. Eisenson and M. Ogilvie, Speech Correction in the Schools.
Margaret Hall Powers, "Functional Disorders of Articulation - Symptomotology and Etiology" in L. Travis, Handbook of Speech Pathology.
W. Johnson, Keaster, Edney, Brown, and Curtis, Speech Handicapped School Children, Revised Edition, 1967.
Charles Van Riper, Speech Correction, Principles and Methods. (New Jersey: Prentice-Hall, 1964).

5. Mack D. Steer, Project Director, "Public School Speech and Hearing Services" in Journal of Speech and Hearing Disorders, Monograph Supplement 8, July 1961.

## IV. FINDINGS AND RECOMMENDATIONS

For purposes of clarity of presentation and organization, the results and recommendations will follow the outline of the observation form developed by the evaluation chairmen. The recommendations are the responsibility and reflect the interpretation and thinking of the evaluation chairmen.

### A. Identification Procedures

#### 1. Screening Methods

The percentage of children identified as being in need of speech therapy (8.3 per cent of the population of the 177 schools served nearly 7000 pupils—figure supplied by the Bureau of Speech Improvement) was slightly higher than the reported national average of approximately 5 per cent. The basic screening method used was an interview by the speech teacher with each child in his own classroom in which he answered questions. It appears that each school was screened in this manner. Other methods included having the child read a passage or having him count, name colors, or other stereotyped speech performances. Children with language problems were referred to the speech teachers by the classroom teachers. Although the overall identified population was within expected percentage levels (we should also consider that there was a reported waiting list of over 2,000 children, who were eligible and would

fill vacancies as they occurred, based on the figures supplied by the 30 of the 38 teachers who returned the questionnaire), it is possible that the identified children basically represented only one specific type of speech disorder, articulation or speech sound error. The screening method, using stereotyped speech responses, does not easily identify speech disorders such as clinical stuttering. The screening method that was used, as with most screening techniques, involved listener experience and bias. Most of the speech teachers appeared ready to listen for articulation errors, particularly lingual protrusion (46 per cent of the total number of children instructed), while relatively fewer teachers identified the bulk of the voice cases and the stutterers.[1] Permitting the classroom teacher to make the initial identification of the children with language problems, considering the fact that the teachers lack the proper training and experience to identify such problems, is not an acceptable practice. Another screening procedure which was neglected, although there may be good reason for this omission, such as lack of equipment and teacher time, was audiometric screening. This area should at least be given administrative consideration for next year's program.

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1. See Appendix A, Table I.

Recommendations for Screening

Some of the following recommendations were already made in a previous report (Center for Urban Education, Speech Therapy Services for Disadvantaged Children in Nonpublic Schools, 1966) and they appear to be useful techniques for the coming year.

The speech teacher should routinely screen each entering third through seventh grade pupil, individually and in private, using a rating scale (to measure severity) which would evaluate the child in all possible speech parameters: articulation, rate, rhythm, loudness, voice (appropriate pitch), quality, communicative effectiveness, overall intelligibility, and oral language usage.[2] The speech teacher should use as much informal conversation as possible, as well as those techniques already in use, such as serial naming and reading aloud. The rationale for this procedure is that, by the age of eight years, a child is expected to have completed his speech sound acquisition. Therefore, the presence of articulatory errors in the third grade, when not attributable to second language learning or to non-standard dialect, indicates the

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2. Mack D. Steer, Project Director, "Public School Speech and Hearing Services" in Journal of Speech and Hearing Disorders, Monograph Supplement 8, July 1961.
Martha E. Black, Speech Correction in the Schools, (New Jersey: Prentice-Hall, 1965).

possible need for clinical help. Children in the first two grades should be referred for screening by the classroom teacher. With a minimum of time, which would not necessarily be repeated every year, an orientation program for teachers could be developed which would describe the various speech and language problems. This could be followed by a bulletin which would also describe speech disorders. A referral slip should be distributed to each teacher on which oral communicative disorders would be checked and sent to the speech teacher. The orientation program would also serve as an indirect way of improving communication between the speech teacher and the rest of the faculty of the school. In addition to the methods recommended, for the coming academic year (1967-68), each therapist who has already compiled a list of children's names who were in therapy or on a waiting list could screen these children and establish therapy groups almost immediately.

2. Diagnostic Testing

Diagnostic testing, as indicated by the questionnaire responses, was limited to a formal test of articulation with only informal clinical judgements of voice quality, loudness, rate and rhythm. Although it is understood that diagnostic testing involves a fair expenditure of time, it is time well spent. As a result of good diagnostic testing, more accurate decisions could be made as to whether or not a child needs therapy and the type of therapy best

suited for a particular child.[3] It is possible that the speech teacher will need additional training in order to become a competent diagnostician. This could be accomplished during the early in-service training program.

Recommendations for Diagnostic Evaluations

Diagnostic procedures might include the following:[4] an evaluation of the peripheral speech mechanism including the structure and functioning of the articulators; a phonetic analysis of speech sound production using a pictorial approach, including responses to auditory and visual stimulation; an analysis of verbal diadochokinesis (rhythmic alternating movement); and if necessary, a receptive and expressive vocabulary test and/or the Illinois Test of Psycholinguistic Abilities; a thorough evaluation of stuttering including attitudes, situational and word fears and a symptom analysis; a voice evaluation including the determination of habitual and natural pitch; a descriptive evaluation of vocal quality disorders, special tests of handedness, visual motor abilities, etc., should be given whenever necessary. It is also possible that children in need of special diagnostic evaluations could be referred to one of the hospital or college clinics located in the city.

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3. Martha E. Black, Speech Correction in the Schools, (New Jersey: Prentice-Hall, 1965).

4. Frederic L. Darley, Diagnosis and Appraisal of Communication Disorders, (New Jersey: Prentice-Hall, 1965).

B. Referral System

The information derived from the questionnaire indicates that referrals of many types were made. Speech teachers apparently were aware of ancillary services and took advantage of them. This was one area in which there was a pronounced improvement over last year's abbreviated program. The teachers made many referrals for medical, social and psychological services. There was no way of estimating the percentage of completed referrals and the method by which the information was related back to the teacher.

Recommendations for the Referral System

In order to continue to improve this vital aspect of the program, recommendations substantially offered in last year's evaluation report are presented once again. A decision for referral should be made after the speech supervisor, the classroom teacher, an administrator and the parents are informed and understand that a child's progress in therapy is dependent upon the decision reached by the referral source. This group should indicate to whom the referral should be made. Parents should be encouraged to discuss the problem with their family physician to determine whether or not he can recommend a particular professional. If he cannot, then the school could help to find an appropriate agency. It is possible that in some cases, speech therapy will be carried on even in the absence of the information sought from a referral agency. For some children, therapy may have to be discontinued until additional

information is obtained. As far as coordination and follow-up of referrals, this could be the responsibility of the speech supervisor. This person would have to assume the responsibility for seeing to it that all referral sources have responded to follow-up in these instances where no action has been taken, and for reporting back to the school the information obtained from the referral agency.

C. Therapy

The program was adequately administered in terms of speech teachers' assignments to schools, scheduling of children (children scheduled for their half hour a week for the entire year, and assigned to the same group week after week), attendance, clinical recordkeeping, and lesson plan writing. The establishment of small therapy groups of children (from 5 to 8 children in a group) of similar age and with similar defects was in keeping with the recommendations of recent professional thought. The major problems were too large a therapy case load per teacher, insufficient time for each of the groups, an average of a half-hour a week of therapy, and not enough flexibility in the therapy procedures used for the various age levels serviced.

The average case load per speech teacher (200) was somewhat higher than the national average (an average of approximately 150 children).[5]

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5. See Appendix A, Table 1.

Since the figure of 200 children combines the number of children seen by the full time and the part time speech teachers, a further analysis of the case load was done based on the number of schools services as an indication of full or part time teachers. The average case load of the speech teachers working in 5 to 8 schools (presumed to be full time employment) inclusively, was approximately 255 children.[6] The average case load of those speech teachers servicing from 2 to 4 schools (presumed to be part time employment) inclusively, was approximately 113 children.[7] These figures would indicate that the speech teachers were carrying too heavy a case load. The speech teachers themselves who responded to the questionnaire, expressed the opinion that this case load was high. The heavy case load in combination with visits to somewhere between 5 to 8 schools prevented them from offering more of their services to those who needed them most.

The therapy sessions that were evaluated by the observers were well organized, utilized visual aids, and held the interest of the younger children. However, the observers believed that the lessons did not appear to be as stimulating to the groups of older children. Therefore, revision of materials and lesson plans is needed for the older children served in the program. Young children will attempt to change their speech and participate in activities directed by the speech teacher for the extrinsic motivation and reward inherent in this type of lesson, whereas older children are not responsive to these techniques

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6. See Appendix A, Table 2.

7. See Appendix A, Table 3.

but need strong intrinsic reasons to change a behavior as fundamental as their speech.

Although there was flexibility in therapy generally noted, most of the speech teachers used the procedures described in the Curriculum Guide of the Bureau of Speech Improvement. The technique most often observed was a combination of auditory stimulation, auditory discrimination and phonetic placement. As therapy techniques, such procedures have great value and are time honored methods in the field of speech pathology. What is apparently needed is a sequence of therapy methods based on the readiness exhibited by the children. There is a definite need for the teachers to become aware of a complete sequence of therapy events, including the searching for behavioral clues which suggest that children are ready for a next step. The sequence suggested would begin with auditory stimulation methods. When children have mastered this stage, the teachers can utilize a phonetic placement technique, if necessary.

There is no doubt that many children profited from the therapy offered in this program. This is best seen by examining the number of children who had been discharged from therapy (16 per cent, figure supplied by the Bureau of Speech Improvement) as well as the number of children who showed improvement following therapy (72 per cent, figure supplied by the Bureau of Speech Improvement). Although the discharge figure of 16 per cent is somewhat lower than the expected national average (estimated 30 per cent), this figure, in combination with the

high percentage of children who showed improvement, is a definite indication of an effective program.

Another area which showed significant improvement (as indicated by the speech teachers who completed the questionnaire) over last year was the development of communication by the speech teachers with other school personnel and with the parents of children in therapy. Many of the speech teachers who completed the questionnaire indicated that they would like more time to develop and expand their parent and teacher conferences.

Supervision of all the speech teachers was carried out by the director of the program and one clinical supervisor. These two individuals made over 135 visits to the various schools in the program. Each therapist was seen at least once a term and most were seen several times. Supervisors were always available on call to the speech teachers. On the surface this would appear to be satisfactory supervisory time, but when one considers that close to 7,000 children were seen in the program (6,965 children, figure supplied by the Bureau of Speech Improvement), a recommendation for additional supervisors is made in order to insure maximum teacher efficiency. In this type of program, supervisors evaluate the clinical proficiency of the speech teachers, serve as consultants for therapy, evaluate difficult cases, as well as coordinate and generally administer the program. It should be noted that this year the director and the supervisor conducted a very fine in-service program for the speech teachers, which included lecturers

arranged by the Bureau of Speech Improvement and included participants from outside agencies.

In summary, the therapy programs offered this year were of high quality and met their expressed purpose. However, as is true for any pupil-teacher (therapist) situation, there is always room for improvement. The following recommendations are offered in that spirit.

Recommendations for Therapy

One method of establishing greater administrative control over the entire speech program would be through the creation of speech and hearing centers, perhaps one in each borough of the city under the administration of a director who would have full administrative responsibility for the program including the assignment of speech teachers, their orientation, supporting relationships with the nonpublic school administrators, developing guidelines for screening, diagnostics, referrals and recordkeeping. Each center should be administered by a supervisor who would be responsible for all schools in that borough. This person would have administrative and diagnostic responsibilities, as well as other duties. In addition, each center should have at least one experienced speech teacher who would be available to do the more complex speech diagnostics as well as to serve as an itinerant therapist who would provide individual therapy for those children in the area who have serious problems and could not profit from the usual group therapy. This procedure would help to ensure that only those children who are in

need of speech therapy would be receiving it. More speech teachers may be needed in order to ensure that the majority of children in the program receive at least two half-hour therapy sessions a week. It is also possible that with improved diagnostics and increased supervision of the diagnostics, the case load would also be reduced. An average case load between 90 and 100 children per therapist is recommended and should not exceed 150.

Although flexibility is to be encouraged, the speech teachers would benefit from a demonstration of the best procedures available in current therapy programs. This could be accomplished by having a curriculum conference of leading speech pathologists from the metropolitan area and/or a series of lectures presented by consultants during the orientation program.

D. Facilities

The program met the minimum requirements established by many state guidelines for physical facilities and equipment. The nonpublic schools have made an effort to provide proper facilities for the speech teacher. In some isolated cases, there is still a need for better therapy rooms (well located, quiet). Many teachers developed their own highly stimulating games, pictures, and other materials.

E. Clinicians and Their Preparation for the Program

As was reported in last year's evaluation, the teachers employed in this project were representative of public school teaching staff. The information supplied by the Board of Education indicated that they

all held at least minimum certification from the New York City Board of Education. One teacher had a doctorate degree, nine had masters degrees, and eleven teachers had, in addition, New York State Certification. However, since the majority of the teachers have only a bachelors degree and one or two years' experience, it is advisable to continue to offer the orientation lectures that were developed during the present year and to seriously consider the recommendations made under the therapy heading.

## V. SUMMARY OF MAJOR RECOMMENDATIONS

A. Screening - Speech teachers' screening of each child in the third through the seventh grades using a clinical rating scale was recommended; classroom teacher training followed by teacher referrals was also indicated as a supplementary form of screening.

B. Diagnostics - Additional diagnostic tests should be given to children who are being considered for therapy. Speech teachers to be instructed in diagnostic methods. Supervisors and experienced teachers could assist in diagnostic evaluations. The use of college and hospital speech and hearing clinics could also be utilized.

C. Referrals - Procedures for referrals, particularly the role played by the parent, were discussed. Methods for follow-up referrals were also indicated.

D. Therapy - Greater flexibility in therapy methods, particularly for older children, was urged. Systematic therapy schemes developed in consultation with other professionals in the metropolitan area were suggested. Smaller case loads permitting more frequent teacher contacts with children were also recommended.

E. Therapy - The establishment of regional centers (located in at least four boroughs) under the direct administration of a speech supervisor and staffed by one or two experienced speech teachers, would help

develop all aspects of the clinical program. The major aim of these centers would be to insure supervisory contact with all levels of the program.

F. Therapy - There is a need to improve and expand speech teachers' contacts with parents of children in therapy and with other school personnel. More time should be allocated to the speech teacher for this purpose.

G. Orientation of Teachers - Continue to offer the orientation programs that were initiated last year. Guest speakers from the colleges in the metropolitan area should be invited to lecture about various aspects of the program.

Recommendations for Next Year's Project Evaluation

A. If time permits, a small pilot study could be done measuring the effectiveness of a segment of the total therapy program. This should be done by evaluating the experienced and less experienced therapist, as they use their typical therapy procedures, for at least six months of therapy time. A sample of speech should be elicited by the evaluation staff. Judgment of speech production would be made by a trained speech pathologist listening to randomly selected pre- and post-therapy recordings.

B. A replication of this year's evaluation is also recommended. In addition, a questionnaire study should be made to solicit the opinions

of parents whose children are in therapy and the opinions of school personnel concerning the effectiveness of the program. Such a questionnaire was developed for this year's evaluators, but it could not be used because of administrative difficulties. In the final analysis, the real effectiveness of the program is to be seen through the eyes of those who view the child in his life's experience.

# APPENDIX A

## TABLE 1

NUMBER OF CHILDREN IDENTIFIED ACCORDING TO SPEECH DISORDER - DERIVED FROM QUESTIONNAIRE

| Speech Clinician | Articulation | Cleft Palate | Language Impairment | Stuttering | Voice | Total |
|---|---|---|---|---|---|---|
| 1 | 234 | 0 | 8 | 8 | 0 | 250 |
| 2 | 229 | 1 | 1 | 28 | 17 | 276 |
| 3 | 209 | 1 | 1 | 52 | 20 | 283 |
| 4 | 191 | 1 | 2 | 3 | 38 | 235 |
| 5 | 87 | 1 | 3 | 33 | 3 | 127 |
| 6 | --- | --- no response on this item --- | | | --- | --- |
| 7 | 23 | 2 | 3 | 14 | 3 | 45 |
| 8 | 171 | 1 | 11 | 51 | 16 | 250 |
| 9 | 236 | 0 | 3 | 18 | 12 | 269 |
| 10 | 235 | 1 | 4 | 11 | 0 | 251 |
| 11 | 80 | 0 | 8 | 6 | 0 | 94 |
| 12 | 235 | 1 | 0 | 31 | 0 | 267 |
| 13 | 220 | 1 | 0 | 22 | 0 | 243 |
| 14 | 212 | 1 | 8 | 9 | 34 | 264 |
| 15 | 235 | 2 | 1 | 14 | 7 | 259 |
| 16 | 256 | 2 | 0 | 16 | 5 | 279 |
| 17 | 211 | 1 | 2 | 8 | 0 | 222 |
| 18 | 78 | 1 | 0 | 2 | 10 | 91 |
| 19 | 240 | 0 | 0 | 10 | 0 | 250 |
| 20 | 187 | 0 | 0 | 26 | 0 | 213 |
| 21 | 293 | 1 | 0 | 3 | 0 | 297 |
| 22 | 148 | 0 | 4 | 15 | 0 | 167 |
| 23 | 273 | 0 | 0 | 28 | 4 | 305 |
| 24 | 123 | 1 | 6 | 19 | 0 | 149 |
| 25 | 96 | 1 | 1 | 13 | 0 | 111 |
| 26 | 134 | 0 | 3 | 41 | 5 | 183 |
| 27 | 39 | 0 | 0 | 0 | 0 | 39 |
| 28 | 73 | 0 | 0 | 3 | 1 | 77 |
| 29 | 65 | 0 | 0 | 4 | 7 | 76 |
| 30 | 88 | 0 | 1 | 9 | 4 | 102 |
| Total: | 4901 | 20 | 70 | 497 | 186 | 5674 |

TABLE 2

CASELOAD SIZE OF CLINICIANS ASSIGNED TO
BETWEEN FIVE AND EIGHT SCHOOLS
(Presumed to be full-time)

| Number of Schools Serviced | Total Caseload Size |
|---|---|
| 5 | 285 |
| 5 | 257 |
| 5 | 268 |
| 5 | 251 |
| 5 | 300 |
| 6 | 250 |
| 6 | 277 |
| 6 | 233 |
| 6 | 266 |
| 6 | 280 |
| 6 | 292 |
| 6 | 333 |
| 7 | 235 |
| 7 | 267 |
| 7 | 250 |
| 7 | 185 |
| 8 | 250 |
| 8 | 208 |
| Total: 111 | 4,687 |

TABLE 3

CASELOAD SIZE OF CLINICIANS ASSIGNED TO
BETWEEN TWO AND FOUR SCHOOLS
(Presumed to be part-time)

| Number of Schools Serviced | Total Caseload Size |
|---|---|
| 2 | 125 |
| 2 | 106 |
| 2 | 41 |
| 2 | 77 |
| 2 | 106 |
| 3 | 95 |
| 3 | 86 |
| 3 | 171 |
| 3 | 165 |
| 3 | 183 |
| 3 | 79 |
| 4 | 129 |
| Total: 32 | 1,363 |

## Appendix B - INSTRUMENTS

SPEECH THERAPY FOR DISADVANTAGED PUPILS IN NONPUBLIC SCHOOLS

### List of Instruments


| | |
|---|---|
| Letter of Introduction | B1 |
| Speech Therapy Teachers' Questionnaire | B2 |
| Information from Direct Observation | B7 |
| Interview Information | B9 |

Center for Urban Education
Speech Therapy, Non-Public School
ESEA Title I
Evaluation Information

Dear Speech Therapist:

The Center for Urban Education is evaluating the speech therapy program in the non-public schools which is provided by the Title I Act. Part of this evaluation will be based upon the information collected by means of the enclosed questionnaire. This questionnaire is being sent to all of the therapists in this program. Therefore, this information is important to us, and we should appreciate your thoughtful and frank answers to all of the questions. This information will be processed only by the staff of the Center for Urban Education who are directly involved in this project. Since we expect to report the information obtained from these questionnaires using group statistical methods, we do not want you to sign this questionnaire.

Please read through the entire questionnaire to get an idea of its structure, before beginning to answer the questions. Please answer all the questions to the best of your ability, even if they seem ambiguous. If you feel that you need additional space for responses, please feel free to use the backs of the question sheets. The completed questionnaire is to be returned in the enclosed return envelope by _____.

Thank you very much for your cooperation.

Very truly yours,

Seymour Rigrodsky, Ph.D.
Project Director

Center for Urban Education
Speech Therapy, Non-Public School
ESEA Title I
Evaluation Information

## Speech Therapy Teachers' Questionnaire

1. In how many schools do you do speech therapy?_____

2. In how many schools do you:
   a. use different rooms during a single visit?_____
   b. use different rooms during successive visits?_____
   c. share the same room with other school personnel during a visit?_____
   d. have a room which is used solely by you during the week?_____
   e. have locked files?_____
   f. have space for storing equipment and materials?_____

3. Check the kinds of equipment and materials you like to have always on hand for therapy and diagnosis.
   a. mirror_____
   b. blackboard_____
   c. appropriate size table_____
   d. appropriate size chairs_____
   e. auditory trainer_____
   f. pure tone audiometer_____
   g. Language Master_____
   h. tape recorder_____
   i. phonograph and_____ appropriate records_____
   j. others (specify)
      _____
      _____
      _____
      _____
      _____
      _____
      _____
      _____

4. How often are these things available to you? (Please write "always," "frequently," "sometimes," or "never" after each one.)
   a. mirror_____
   b. blackboard_____
   c. appropriate size table_____
   d. appropriate size chairs_____
   e. auditory trainer_____
   f. pure tone audiometer_____
   g. Language Master_____
   h. tape recorder_____
   i. phonograph_____
   j. appropriate records_____
   k. others (specify)
      _____
      _____
      _____
      _____
      _____
      _____
      _____
      _____
      _____
      _____

5. Briefly describe the speech and hearing screening procedures you use to identify all those children who may be in need of speech therapy._____

6. Do those children who fail your screening procedures receive further speech diagnostic evaluation? yes____ no____
If so, briefly describe these procedures._____

7. What system of reporting do you use in:
   a. reporting the results of your screening procedures to classroom teachers or other school personnel?_____

   b. reporting the results of further diagnostic work (if any is done) to the classroom teacher or other school personnel?_____

8. What procedures do you follow in referring children for other kinds of testing or evaluation?_____

9. If you have referred children for such evaluations, please check the kinds of evaluations you have requested.
   a. psychological_____
   b. general medical_____
   c. neurological_____
   d. psychiatric_____
   e. dental_____
   f. otolaryngological_____
   g. audiological_____
   h. others (specify)
      _____
      _____

10. What is the total number of children you see each week
    a. in individual therapy?_____
    b. in group therapy?_____

11. Do you have a waiting list? yes____ no____
    If so, how many children are on it?_____

12. How many children in each grade do you see in therapy?

| | | | |
|---|---|---|---|
| K | ____ | 7 | ____ |
| 1 | ____ | 8 | ____ |
| 2 | ____ | 9 | ____ |
| 3 | ____ | 10 | ____ |
| 4 | ____ | 11 | ____ |
| 5 | ____ | 12 | ____ |
| 6 | ____ | Total | ____ |

13. How many children do you now have in therapy in each of the following classifications? (Enter each pupil only once.)
    a. articulation _____
    b. cerebral palsy _____
    c. cleft palate _____
    d. hard of hearing or deaf _____
    e. language impairment or delay _____
    f. stuttering
    g. voice
    h. others (specify) _____
    _____

14. How is the size of your caseload determined?_____
    _____
    _____

15. How long is your average individual therapy session?_____minutes

16. How long is your average group therapy session?_____minutes

17. What is the average number of children in your group therapy sessions?_____

18. How many children are in your smallest therapy group?_____

19. How many children are in your largest therapy group?_____

20. What system of reporting do you use in:
    a. reporting progress in therapy to classroom teachers or other school personnel?_____

    b. reporting progress in therapy to parents or guardians?

21. Since there are always good and bad features of any program, we would like you to give us your opinion about the positive and negative aspects of this program in the following areas (where applicable).
    a. materials and equipment_____

    b. screening procedures_____

    c. evaluation procedures_____

    d. referral system_____

    e. caseload_____

    f. therapy techniques_____

    g. reporting to classroom teacher or other school personnel

    h. reporting to parents or guardians_____

22. We would appreciate any recommendations you might wish to offer in order to improve the speech and hearing services which you now provide._____

_____

_____

_____

_____

_____

_____

## INFORMATION FROM DIRECT OBSERVATION

I. Preparation for therapy session
   A. Materials
      1. Appropriate for group? _____

_____

_____

      2. Sufficient quantity for entire group? _____

_____

_____

   B. Lesson Plan (observer's evaluation)

      Comment: _____

_____

_____

   C. Physical Plant
      1. Comment: (brief description) _____

_____

_____

_____

      2. Seating arrangement of therapist and children: (brief description)

_____

_____

_____

II. Therapy Session
   A. Organization
      1. How long did it take for session to start? (minutes) _____
      2. Introduction and explanation of activities

         Comment: _____

_____

B. Procedures

1. Did the activities seem suited to the stated goals?

Comment: _____

_____

_____

2. Did all the children have an opportunity to participate?

Yes_____ No_____

3. Was participation related to competition among the children or were they given equal opportunities to participate?

Comment: _____

_____

_____

4. Briefly describe the general behavior of the children: _____

_____

_____

_____

5. Were materials used in the therapy session?

Comment: _____

_____

_____

_____

6. How was the session terminated? E.g., did it draw to some logical ending point?

Comment: _____

_____

_____

_____

## INTERVIEW INFORMATION

I. Preparation for therapy session (questions to be asked before the observation)

A. Identification information

1. How many children are scheduled in this group? _____
2. How many children were present on the day of the observation? _____
3. How was the grouping determined? E.g., type of disorder, time considerations, age, class, etc. _____

_____

_____

B. Organization of therapy session

1. Is there a lesson plan? yes_____ no_____
   If yes, what kind? E.g., written? In how much detail? _____

_____

_____

2. Did therapist indicate she is following any prescribed syllabus or method such as the Board of Education Curriculum Guide? Yes _____ No_____
   Why?_____

_____

_____

_____

3. What materials are to be used in this session? (list) _____

_____

_____

C. Goals

1. General goals _____

_____

_____

2. Specific goal of session to be observed._____

_____

_____

II. Evaluation of therapy session (to be asked after observation)

Statement to be elicited from the therapist indicating whether the session was successful and why: _____

_____

_____

_____

# APPENDIX C

## Staff List

Dr. Seymour Rigrodsky, Evaluation Chairman
Associate Professor of
Speech Pathology and Audiology
Teachers College
Columbia University

Mr. Ronald Baken
Instructor
Department of English
Columbia College

Miss Doris Jacobs
Instructor
Department of Speech
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Mrs. Eleanor Morrison
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Miss Marjorie Shriro
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